SAFER CORNWALL

Kernow Salwa

Executive Summary

Safer Cornwall

Adult A

Date of Death: March 2020.

Author: Paul Northcott

Date the review report was completed: 03/02/2021

Contents

1.0 Review Process

1.1 This summary outlines the process undertaken by the Safer Cornwall Partnership domestic homicide review panel in reviewing the death of Victim A who was resident in their area.

1.2 The following pseudonyms have been used in this review to protect the identities of the relevant people who were involved;

- Adult A – Deceased female
- Adult B – Husband
- Adult C – Son

1.3 The decision to commission a review was taken by the Chair of the Safer Cornwall Partnership in April 2020. The Home Office had been informed of the decision to undertake a review on the 19th May 2020. The Independent chair was appointed on 1st May 2020 and the first panel meeting was held on the 21st July 2020.

1.4 All agencies that potentially had contact with Adult A and her family prior to the point of her death were contacted and asked to confirm whether they had involvement with them.

1.5 Members from the relevant agencies were then invited to become panel members. Additional inquiries were made with the Polish Embassy, OPOKA[1] and Poles in Need CIC[2] to ascertain whether Adult A had asked for additional help and support during the period covered by this review. These organisations had no record of contact.

1.6 Following a comprehensive review of the initial chronologies (provided by Police, Royal Cornwall Hospital Trust and Cornwall Foundation Trust, Primary Care – GP, First Light) the Panel decided that there was no requirement for Individual Management Reviews (IMR). This decision was based on the fact that there was little contact with the family and limited information recorded by agencies. The Panel decided that information could be more effectively gathered through interviewing the appropriate professionals involved in this case (Police, GP staff, Health staff and those providing Domestic Abuse Support Services (First Light)) and by those involved identifying and discussing the themes which have been highlighted in this report at section 7. The DASH forms completed in this case were also reviewed as were policy documents.

1.7 All of the relevant agencies identified independent and experienced staff members to complete chronologies. These members of staff didn't know the individuals involved, or had direct involvement in the case. None of them had direct line management responsibility for any of the professionals who had been involved with the family.

1.8 Additional information was also reviewed by the Chair of the Panel and this included reading national DHRs involving Polish nationals, and reviewing policies and procedures.

2.0 Contributors to the Review

[1] Opoka is a Polish voluntary organisation set up in the UK to support Polish women and children who are experiencing the devastating and damaging consequences of Domestic Violence and Abuse.

[2] Poles in Need CIC – Is a Polish voluntary organisation which supports families and individuals who find themselves in difficult situations. This includes those who are suffering in their personal and family life due to social isolation, discrimination, poverty, mental health issues, safeguarding concerns and domestic violence.

2.1 The contributors to the DHR were;

- Safer Futures – Chronology/Information/Advice.
- Devon and Cornwall Police – Chronology, access to investigative records/Domestic Abuse Stalking and Harassment and Honour Based Violence (DASH) risk assessments/MARAC minutes.
- Cornwall Partnership NHS Foundation Trust (CFT) and Royal Cornwall Hospital Trust –Chronology/Information/advice.
- Adult Social Care – Information/advice.
- General Practitioner (GP) Services- Chronology.
- Cornwall housing – Information/advice.
- We Are With You [3](formally Addaction) – information.

2.2 Specialist domestic abuse advice and scrutiny was provided by the members from Safer Futures[4].

2.3 In terms of the wider issues faced by the Polish community additional advice was sought from the Devon and Cornwall Police Diverse Communities Team, the Social Inclusion Officer for the County concerned and from a Polish national living in the area who had experienced domestic abuse.

2.4 Specialist support in terms of advice relating to domestic abuse and the Polish Community was provided to the Panel by Vesta - Specialist Family Support CIC. Vesta - Specialist Family Support CIC support Polish families with domestic violence issues through therapeutic courses for victims, counselling and short one-to-one interventions with individuals engaging in abusive behaviour. They also focus on improving parenting skills and general well-being of the Polish families.

2.5 Adult A's parents, her son, her brother and Adult B were invited to contribute to the review. All of these individuals were provided with a leaflet prepared by the Home Office about the DHR process. The family were also provided with the Advocacy After Fatal Domestic Abuse Leaflet and signposted to support services. The family members made the decision that they did not want to take part in the review process. Despite several attempts to engage with Adult B (through the police and direct contact by the Chair) he chose not to take part in the DHR process.

3.0 The Review Panel Members

3.1 The Panel for this review were made up of the following representatives;

- Paul Northcott-Independent Chair
- Temp Detective Chief Inspector Peter Found - Devon and Cornwall Police
- Detective Sergeant Rob Gordon – Devon and Cornwall Police
- Martin Bassett- Safeguarding Adults Board (SAR Manager)
- Vanessa Fudge[5] - Cornwall Council (DA Coordinator)
- Mel Francis – Safer Futures (Service Manager)

[3] Drug and Alcohol Support Service
[4] Safer Futures is a charity supporting people in Cornwall, Devon and Wiltshire who have been affected by domestic abuse and sexual violence.
[5] Domestic Abuse Co-ordinator

- Zoe Cooper[6] – CFT and RCHT (Consultant Nurse for Integrated Safeguarding Services).
- Alexandra Morgan-Thompson – Cornwall Housing
- Laura Ball [7]- Cornwall Council (Domestic abuse and Sexual Violence Strategy Manager)
- John Groom – NHS Kernow Clinical Commissioning Group (CCG – Director of Planned Care)
- Ewa Wilcock - Vesta –(Specialist Family Support CIC)

3.2 The Safer Cornwall Partnership ensured that there was scrutiny and accountability throughout the DHR process particularly in respect of independence and impartiality. The impartiality of the independent chair and panel members are essential in delivering a process and report that is legitimate and credible. None of the panel members knew the individuals involved, had direct involvement in the case, or had line management responsibility for any of those involved. This was confirmed by agencies at the initial panel meeting.

3.3 The Panel met formally on four occasions. In the interim period and in order to ensure that the review was comprehensive contact was made with panel members on a regular basis to clarify issues and matters of accuracy about their agency's involvement with the family.

4.0 Author of the Overview Report.

4.1 The Safer Cornwall Partnership appointed Paul Northcott as Independent Chair and author of the overview report on 1st May 2020.

4.2 Paul is a safeguarding consultant specialising in undertaking reviews and currently delivers training in all aspects of safeguarding, including domestic abuse. Paul was a serving police officer in the Devon and Cornwall Police and had thirty-one years' experience. During that time he was the head of Public Protection, working with partner agencies, including those working to deliver policy and practice in relation to domestic abuse. He has also previously been the senior investigating officer for domestic homicides.

4.3 Paul had not worked in the Devon and Cornwall Police area since 2015 and retired from the service in February 2017. In that interim period, he had worked in London. During that time, he had no involvement with Safer Cornwall, nor the policy and practices of the Devon and Cornwall Police. Prior to his appointment records were checked to ensure that Paul had no involvement with those police resources involved in this case.

4.4 Paul has been trained as a DHR Chair, is a member of the DHR network and has attended AAFDA[8] webinars.

4.5 At regular intervals Safer Cornwall reviewed Paul's independence and the Panel was encouraged to challenge him and the police IMR submission to ensure that it was

[6] Consultant Nurse for Integrated Safeguarding Services
[7] Domestic Abuse and Sexual Violence Strategy Lead
[8] Advocacy after fatal domestic Abuse.

critically reviewed. No issues were identified by those commissioning the review or by panel members which would have indicated that his independence had been compromised.

5.0 Terms of Reference

5.1 Domestic Homicide Reviews were established on a statutory basis under section 9 of the Domestic Abuse, Crime and Victims Act (2004). The Act, which came into force on the 13th April 2011, states that a DHR should be a review 'of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

a. A person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship or;

b. A member of the same household as him/herself; held with a view to identifying the lessons to be learnt from the death'.

5.2 Whilst there was no conclusive evidence to suggest that Adult B had been involved in the death of his wife, the Safer Cornwall Partnership commissioned a DHR due to the fact that there had been incidents of domestic abuse involving the couple. The review was commissioned with a view to identifying whether the relationship between Adult A and Adult B had been abusive and whether this had indirectly contributed to her death.

The purpose of the review was therefore set to;

- Establish the facts that led to the death of Adult A and whether there was learning in the way in which local professionals and organisations carried out their responsibilities and duties, and worked together to safeguard Adult A;

- Identify clearly the learning, how this will be acted upon, and what is expected to change as a result;

- Apply the learning to service responses including changes to policies, procedures and practice of individual agencies, and inter-agency working, with the aim to better safeguard victims of domestic abuse in Cornwall;

- Identify what needs to change in order to reduce the risk of such tragedies happening in the future and improve single agency and inter-agency responses to all domestic abuse victims and their children through improved partnership working;

- Identify, on the basis of the evidence available to the review, whether the death of Adult A was foreseeable and avoidable, with the purpose of creating a joint strategic action plan to address the gaps and improve policy and procedures in Cornwall and across the Southwest Peninsula;

- Identify from both the circumstances of this case, and the review process adopted in relation to it, any learning which should inform policies and procedures in respect to national reviews and make this available to the Home Office.

5.3 In addition to the above, the following terms of reference were set by the DHR panel and there was a requirement that these needed to be addressed in the overview report;

1. To provide an overview report that articulates Adult A's life through her eyes, and those around her, including professionals.

2. Establish the sequence of agency contact with Adult A, and the members of their household (between the dates of December 2013 and March 2020); and constructively review the actions of those agencies or individuals involved.

3. Provide an assessment of whether the death of Adult A was an isolated incident or whether there were any warning signs that would indicate that there was any previous history of abusive behaviour towards the deceased and whether this was known to any agencies.

4. Seek to establish whether Adult A was exposed to domestic abuse prior to adulthood and the impact that this may have had on the individuals concerned.

5. Establish whether family or friends want to participate in the review and meet the Review Panel.

6. Provide an assessment of whether family, friends, neighbours, key workers (if appropriate) were aware of any abusive or concerning behaviour in relation to the Adult A (or other persons).

7. Review of any barriers experienced by Adult A/family/friends in reporting any abuse or concerns in Cornwall or elsewhere, including whether they knew how to report domestic abuse.

8. Assess whether there were opportunities for professionals to enquire or raise concerns about domestic abuse in the relationship.

9. To review current roles, responsibilities, policies and practices in relation to victims, individuals engaging in abusive behaviour and families of domestic abuse – to build up a picture of what should have happened.

10. To review national best practice in respect of protecting victims and their families from domestic abuse.

11. An evaluation of any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services in Cornwall.

12. Whether the work undertaken by the services in this case was consistent with

their own professional standards, compliant with their own protocols, guidelines, policies and procedures.

13. Establish whether thresholds for intervention were appropriate and whether they were applied correctly in this case.

14. Consideration of any equality and diversity issues that appear pertinent to Adult A or family members e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

15. To clearly identify learning and draw out conclusions about how organisations and partnerships can improve their working in the future to support victims of domestic abuse.

16. To clearly articulate how learning will be acted upon, and what is expected to change as a result.

17. To identify whether, as a result, there is a need for changes in organisational and/or partnership policy, procedures or practice in Cornwall in order to improve our work to better safeguard victims of domestic abuse and their families.

18. To identify good practice.

19. To review any other information that is found to be relevant.

The Review excludes consideration of how Adult A died.

5.4 The methods for conducting DHRs are prescribed by the Home Office guidelines[9]. These guidelines state;

> *'Reviews should illuminate the past to make the future safer and it follows therefore that reviews should be professionally curious, find the trail of abuse and identify which agencies had contact with the victim, perpetrator or family and which agencies were in contact with each other. From this position, appropriate solutions can be recommended to help recognise abuse and either signpost victims to suitable support or design safe interventions'*.

The Panel chose the initial time period for the terms of reference to ensure that it covered the period that agencies had contact with Adult A and her family. This time period was later extended to include a report by Adult A to the Police in July 2009 concerning domestic abuse.

6.0 Summary

[9] Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews; Home Office: Dec 2016

6.1 Adult A was aged forty-seven at the time that she died. Adult A lived with her husband, Adult B, who was also aged forty-seven in a town within Cornwall. Adult A had one adult son who lived in close vicinity to his parents. Both were white Polish nationals.

6.2 In March 2020, Adult B attended the front desk of his local police station. Adult B explained that there was a body at his home address.

6.3 Police officers were dispatched to the address and on their arrival they found that two ambulances were already in attendance. At the address, the body of Adult A was found lying at the bottom of the stairs.

6.4 Later that day, Adult B was arrested on suspicion of murder. Adult B was later interviewed by the police but he denied murdering his wife. Adult B was released from police custody whilst further enquiries were carried out.

6.5 The Police investigation identified that there had been a history of domestic abuse between the couple and that Adult A had been discussed at a Multi-Agency Risk Assessment Conference (MARAC) on the 8TH November 2017.

6.6 Following the Police investigation and the fact that a forensic post-mortem concluded that Adult A's injuries were inconclusive, no charges were brought against Adult B and the case was instead referred to HM Coroner for inquest. At the time of submitting this report the inquest had not been heard.

6.7 The cause of death provided by the pathologist who dealt with this case was a head injury and acute alcohol intoxication.

7.0 Key Issues Arising from the Review

7.1 This part of the report will examine how and why events occurred, information that was shared, the decisions that were made, and the actions that were taken or not taken. It will consider whether different decisions or actions may have led to a different course of events. The analysis section seeks to address the terms of reference and the key lines of enquiry within them. It is also where any examples of good practice are highlighted.

7.2 <u>Evidence of Domestic Abuse in Adult A and Adult B's relationship</u>

7.2.1 There is little known about Adult A's childhood or wider family circumstances. There has been nothing found during the review to suggest that she experienced domestic abuse in her childhood.

7.2.2 From the records held by the police there is evidence that Adult A had disclosed that she was in an abusive and violent relationship as far back as 2009.

7.2.3 There were two reported crimes where the information recorded at the time clearly indicates that Adult A had been assaulted by Adult B (22/12/13, 02/11/17). There is also a recorded domestic abuse incident (21/02/17) where Adult A was identified as being verbally abusive to her husband and a fourth incident where Adult A had contacted a family member via Facebook stating that 'she was still alive and not going to be here

tomorrow'. On these occasions police followed correct procedures, assessed the risks (although this process was frustrated due to language barriers) and initiated appropriate action at the scene. These inquiries included contact with family members and neighbours in order to enhance evidence gathering opportunities. On occasions the follow up process was less effective.

7.2.4 DASH records show that Adult A was afraid that her husband would kill her and that he had made threats in the past to do so. Adult A had stated that Adult B had attempted to strangle her with his hands and that the level of violence was increasing in the relationship in that it was happening every weekend.

7.2.5 The Domestic Abuse Officer (DAO) who had supported Adult A described her as being petrified of her husband to such an extent that she had offered to take her to London in order that she could catch a bus back to her family in Poland. The identified threats and risks involved were acknowledged by those specialised domestic abuse professionals that had contact with Adult A and as a result support was offered to her. Adult A's case was also referred to the MARAC process in 2017.

7.2.6 Following a reported incident on the 22nd December 2013 the police had significant problems in trying to source an interpreter for Adult A and this resulted in the officers who had attended the address submitting a DASH form with their views on the issues within the relationship. This resulted in a 'defaulted'[10] medium risk DASH. Police records state that a further DASH would be completed with an interpreter at a later date but this failed to take place. There was no rationale recorded within police records as to why the additional DASH was never completed and from records no reminders were set or requests passed on to ensure that this task was finalised. As a result of this failing there was no consent to share information and no automatic referrals were ever made to IDVA services (Safer Futures confirmed that they had no referrals). This was poor practice and was a missed opportunity to obtain additional information, offer safeguarding advice and take action to mitigate risks.

7.2.7 Following the incident in 2013 Adult B was arrested but on reviewing the evidence available to them the police decided that further enquiries were necessary. The ability to conduct enquiries was severely hampered as there were no interpreters available and this led to the police making the decision to give Adult B bail. At that time Adult B had bail conditions not to contact Adult A (either directly or indirectly) and not to attend their home address.

7.2.8 Efforts were made by officers to arrange for further statements to be taken from both Adult A and Adult C. Both refused to provide statements and as a result, a police gatekeeper made the decision that this incident did not meet the required evidential test. No further action was taken against Adult B. Access to interpreters is acknowledged as being an issue in the report provided by the police. Research shows that such delays adversely impact on the outcomes of such cases and that individuals engaging in

[10] Defaulted DASH – This DASH is completed by attending officers on the knowledge they have gained from those involved in the incident. Such a DASH is completed when the victim states that they do not want to assist with its completion.

abusive behaviour can adversely influence a victim's decision about progressing their complaint in the interim period[11].

7.2.9 Prior to any charges being authorised following the incident that occurred on the 2nd November 2017 discussions were held with Adult A regarding her safeguarding and the use of a DVPN. Although on this occasion Adult A stated that she did not want a DVPN there was clear evidence of good safeguarding and legislative knowledge by those officers dealing with the case in an attempt to protect Adult A from further abuse. This should be seen as good practice. In this case a DVPN was not necessary as charges were subsequently authorised.

7.2.10 As part of the review process the Panel considered whether Adult B was controlling or coercive[12] in his relationship with his wife. Adult A had disclosed to an IDVA (02/11/17) that Adult B controlled all of the finances and that he did not allow her to work. She stated that as a result of his behaviour she had become very isolated.

7.2.11 Adult A had also stated in a DASH completed in 2017 that Adult B had forbidden her from seeing friends and family including her sister when she had travelled to the UK. Adult A also stated that she was also prevented from having a phone[13] and from going to the shops. She stated that 'I only eat what he buys'. In her words she felt like 'a prisoner in her own home' but was reliant upon him and 'needed him to survive (police records 02/11/17).

7.2.12 The IDVA who had supported Adult A reflected that from what Adult A had said it would appear that she had accepted abuse and coercion as being an integral part of married life. This is not an unusual stance for some victims to take particularly those who have endured years of "intimate terrorism[14]" and that victims can underestimate their risk of harm from those individuals engaging in abusive behaviour and normalise coercive and controlling behaviours[15]. Those advising the review have also stated that such attitudes are compounded by the culture in Poland to domestic abuse which for some victims would provide additional barriers to reporting such matters due to stigma, family loyalty and the mistrust of agencies.

7.2.13 Despite the interventions that were put into place by the IDVA and DAO Adult A continued to state that she loved her husband dearly and that she didn't want him to get into any trouble. The review has been unable to determine whether these comments were made as an ongoing consequence of the coercive control that she had been subjected to over the years. Research[16] has also shown that due to the abusers acts of apologies and loving gestures between episodes of abuse then some victims will seek to believe that their partners are ready to cease their violent episodes.

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[11] Farmer E, Callen S (2012); Barrow-Grint (2016)
[12] Controlling or Coercive Behaviour in Intimate or Family Relationship Statutory Guidance Framework; Dec 2015; Home Office
[13] The police investigation following Adult A's death showed that she did in fact have access to a phone at that time. This would appear to have been purchased by her son.
[14] Intimate terrorism -any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship" WHO
[15] Gibson 2019
[16] Rakovec- Felser (2014)

7.2.14 Adult A was offered numerous support options (details of local and national support agencies including those specialised in supporting Polish families) but it would appear that she did not take them up. Those that dealt with her felt that this was due to her loyalty to her husband and the level of threat that she was constantly under.

7.2.15 In this case Adult A was financially dependent upon her husband and could see no opportunity to become independent without help. Adult A was also subjected to economic abuse[17]. Adult A did not allow her to work (affecting her ability to acquire economic resources) and did not allow her to have a mobile phone which consequently reduced her ability to access and use economic resources. This was recognised by the DAO who had supported Adult A and she was provided with details on how to get a crisis loan to assist her in resolving this issue and this should be seen as good practice.

7.2.16 During the police inquiry Adult A's family stated that they had no specific concerns around her safety in relation to Adult B and if he was being abusive to her they believed that she would have told them. As identified in this report Adult A was loyal to her family and under the control of her husband. In such circumstances it is likely that she would not be in a position to report the abuse.

7.2.17 There were no disclosures of abuse to health services. In March 2017 Adult A did present to her doctor with a number of ailments. At the conclusion of the consultation Adult A mentioned that her mood was low. It would appear that this statement was never explored further with her or if it was there is no record of what was said. This was an opportunity that was missed in terms of engagement and exploring her family circumstances. There have been a number of DHRs that have been published in Cornwall which advocate that the use of routine enquiry by Health services. In this case such an enquiry may have provided the opportunity to discuss the relationship that she had with her husband (**Recommendation 1**)[18].

7.2.18 Following the MARAC meeting held on the 08/11/17 Safer Futures made contact with Addaction to request that they provide additional support to Adult A as they had a Polish speaking employee working for them. Addaction's records have been checked and they have no record of what (if any) contact was made and what additional support was offered. Safer Futures also do not have any records as to what support was offered. Safer Futures also do not have any records as to what support was provided. The representative from Safer Futures who sat on the Panel has confirmed that current working practices would ensure that such a referral would now be followed up.

7.2.19 Although the minutes/recording from the MARAC meeting have been reviewed the Panel have been unable to ascertain if the actions from that meeting had been followed up and finalised. Those on the Panel have also highlighted that Adult A's case would appear to have been closed prematurely and without confirmation that the support provided to her was adequate to meet her needs. This is poor practice in terms of record keeping and effective oversight through the MARAC process.

[17] Economic abuse is a form of abuse when one intimate partner has control over the other partner's access to economic resources, which diminishes the victim's capacity to support themselves and forces them to depend on the perpetrator financially.

[18] Replicates another recommendation agreed as part of (DHR7) in Cornwall which also recommends promoting the use of routine and direct inquiry across all services.

7.2.20 Safer Futures have acknowledged that ongoing support should have been documented and confirmed prior to case closure and have reassured the Panel and the chair that current working practices and supervision is robust in terms of these actions (**Recommendation 2**).

7.2.21 Safer Futures are now moving towards a complex needs approach, where staff look 'outside the box' in order to meet victim's needs.

7.2.22 In 2017/2018 Safe Lives reviewed the MARAC process in Cornwall and set a number of recommendations and actions to improve the service. As a result of the recommendations that were made the MARAC in Cornwall has improved significantly in recent years.

7.3 Alcohol

7.3.1 From the reports recorded in police records (22/12/13, 21/02/17, 02/11/17, 09/12/17) it would appear that both Adult A and Adult B would drink alcohol on a regular basis and on occasions to excess. This was also confirmed by their son and other relatives during the police investigation into the death of Adult A.

7.3.2 Information provided by Adult A would indicate that the two of them would drink alcohol every night. On the night before Adult A died Adult B had purchased a one point five litre bottle of vodka. He and Adult A drank the contents of the bottle, diluting it with juice. Adult B when interviewed by the police stated that he had drank six or seven vodka's before falling asleep. He believed that Adult A had drank more than he did on that night although this cannot be confirmed.

7.3.3 The IDVA who had spoken to Adult A believed that the two of them used to drink vodka although the DAO believed that it was any type of spirit. Adult A had stated to the DAO that she only drank alcohol so that her husband wouldn't drink as much. It would therefore appear that Adult A saw drinking as a way of mitigating the risk of abuse and it enabled her to escape from the troubles in the relationship.

7.3.4 From the information that is recorded it would appear that when intoxicated both individuals would become verbally aggressive and Adult B violent (22/12/13, 02/11/17). During a joint visit between police and IDVA services on the 02/11/17 Adult A had stated that Adult B would only become violent when drinking alcohol and that he was very remorseful afterwards when he would claim that he could not remember hurting her. Adult A's son had also informed his family that when drunk his mother could also become volatile and argumentative, particularly at weekends. From the evidence reviewed this was likely to be a protective response to the verbal and physical abuse that she was enduring from her husband. Alcohol misuse is seen as a major risk factor for increasing levels of IPV[19].

7.3.5 When Adult A was seen by the DAO she had stated that all she wanted was help for her husband to stop him from drinking. Adult A believed her husband would complete an

[19] Gibbs et al (2020)

alcohol treatment programme if offered one, although it would appear that this support option was never made available to him. The Safer Futures representative on the Panel has confirmed that processes are currently in place to provide support, guidance and literature to victims to enable abusive partners to voluntarily refer themselves to such programmes. Improvements have also been made in terms of the liaison with the court IDVA so that treatment programmes can be considered as part of sentencing options. Safer Futures are also working with We are With You to review referral pathways and therefore the Panel felt there was no requirement to duplicate this recommendation.

7.3.6 Forensic samples taken following Adult A's death identified that she had high levels of alcohol in her blood at the time that she had fallen. The levels indicated could according to a toxicologist have induced' confusion, stupor or coma with shallow breathing and risk of death'.

7.3.7 The importance of clear and consistent pathways to help victims and individuals engaging in abusive behaviour cannot be underestimated[20]. In terms of improving the services available to individuals engaging in abusive behaviour (whose risk may increase through alcohol or drugs misuse), Safer Futures (Firstlight and Barnardo's) and We Are With You have developed a domestic abuse and drug and alcohol protocol and action plan. This development which will see the services co-located will align the two agencies, improve joint support planning, and provide integrated training and learning groups. Consideration is also being given to adopting a model which uses behaviour change workers to support individuals with complex needs through assertive outreach approaches. The Vesta - Specialist Family Support CIC representative on the Panel identified that some Polish individuals who are victims of abuse can be reluctant in engaging with such programmes. Those delivering the programmes will therefore need to be cognisant of the complexities of their needs, the risks[21] and that to be effective they may need to be delivered in their native language.

7.3.8 Those working in the county have acknowledged that a lot of work takes place in respect of referral pathways and assertive outreach from a victim perspective for those with more complex needs. However, these services are not as developed for those engaging in abusive behaviours **(Recommendation 3)**.

7.4 <u>The Polish Community</u>

7.4.1 Although it is not known exactly how many Polish nationals there are living in Cornwall and the Isles of Scilly data from the EU settlement scheme shows that 2,160 Polish nationals were registered in the County (Home Office, Nov 2020). Information from the local Authority and the Police appears to show that the Polish community within Cornwall is largely migrant and they are concentrated in specific areas within the County.

[20] Iriss (2020)

[21] Suicide rates of Polish men in Scotland are significantly higher than Scottish men – 31.5 vs 19.4. Factors contributing to suicides among Polish men included employment status, financial status, healthcare access, alcohol and substances misuse, relationships, police and legal involvement (Gorman at all, 2018). Between 2011-18 5 out of 12 Polish prisoners convicted for domestic violence cases killed themselves. Poland has the highest levels of familicides involving partner and children in Europe (Matusiak, 2019)

7.4.2 The true extent of abuse within the Polish community was difficult to determine due to current recording practices in relation to the way that agencies record nationalities. Numerous nationalities can be categorised under one generic term such as 'White European' and as a consequence some groups are completely hidden in official statistics. It is important that agencies accurately record nationalities in order that they can identify trends in domestic abuse and offer services that meet specific victim needs. In this case RCHT, CFT, Housing and Police all had systems in place to record nationality and the fact that Adult A and Adult B were Polish. Safer Futures identified that their diversity data needed to be more specific to accurately reflect demographics and that this would enable them to change their approach to effectively meet client need **(Recommendation 4)**.

7.4.3 The diverse communities officer and other agencies confirmed that many of the Polish women in the County do not speak English. There are a lot of factors contributing to some individuals from diverse communities not using or learning English such as a short stay in the country, caring duties, long working hours and financial constraints (Johnson, 2015). There is also an acceptance that language is often used by perpetrators to exert abuse, e.g. they ridicule partners who try to speak English which discourages them from learning it. This language barrier can prevent women from knowing about and accessing domestic abuse and other welfare services.

7.4.4 Concerns have been raised that Adult A's isolation was, in part, due to cultural barriers and an acceptance that domestic abuse was part of her family life[22]. The Vesta - Specialist Family Support CIC representative on the Panel has stated that domestic abuse continues to be hidden within the community and that there is little trust of mainstream services. The review has been unable to verify whether Adult A had such a mistrust or that she was aware of the services available to support her.

7.4.5 The Vesta - Specialist Family Support CIC representative also highlighted that in their experience some domestic abuse services can be restrictive in their approach to the needs of victims from ethnic communities. Polish clients often need far more support for practical issues such as housing and finance. Signposting to other services is often not enough and without effective interpreter services clients find it difficult to access the support that they are offered. This process often leaves the client feeling that no one is able to help them and consequently they are then seen as voluntarily disengaging with services. This is a perpetual process that means that those in the community that suffer from abuse are unable to break the cycle or have confidence in the services that are available to them. Such barriers can be overcome by ensuring that where possible domestic abuse support services have a workforce that reflects the community that they serve. The Vesta - Specialist Family Support CIC representative identified that the most effective way of supporting victims is to make the IDVA service accessible by employing a Polish speaking domestic violence worker. As an organisation they have identified that the employment of such a worker will significantly increase the numbers of Polish clients using the service and improve engagement opportunities.

[22] Notes from Poland (2020)

7.4.6 The Panel identified that language is a barrier to support and that those in the Polish community often prefer to seek support from Polish speaking professionals in private practice, both here in the UK and in Poland. This means that the true extent of abuse and victimisation is often not apparent to mainstream services.

7.4.7 The Panel acknowledged that there are issues with sourcing interpreters in a timely fashion in Cornwall for all agencies. The true impact of this on victims of domestic abuse could not be verified. Agencies did however accept that where there is a quicker response then it is highly likely that there would be better outcomes for victims of abuse. Agencies in Cornwall should therefore look at reviewing and developing interpreter services that are flexible to meet current and future needs. The Vesta - Specialist Family Support CIC representative on the Panel also identified that professionals working with foreign nationals would also benefit from completing training on using interpreters and this should be considered as part of that review **(Recommendation 5).**

7.4.8 The Police have commissioned interpreter services in line with National approved practice. These services involve freelance interpreters and the procurement frameworks that govern them and their operational effectiveness are not suitable for the needs of the Police. This case did highlight that operational officers can, on occasions, have problems in appropriately sourcing interpreters (paragraphs 16.3.8/16.3.9). At present the commissioning arrangements for this service are under review on a national basis and the Force concerned in this case are looking at the benefits of what is being proposed. Such a move would ensure a consistent and standardised approach to the recruitment, training and deployment of interpreters which would meet the needs of victims **(Recommendation 6).**

7.4.9 The Panel members further acknowledged that any interpreters used in relation to domestic abuse cases would benefit from domestic abuse training to ensure that they are meeting the needs of the victim and that they are eliciting all of the information required by agencies to progress a case (**Recommendation 7**).

7.4.10 In terms of the availability of information for non-English speaking victims' agencies have confirmed that this is an issue. The availability of multilingual literature across all agencies relating to domestic abuse services was found to be variable (**Recommendation 8**).

7.4.11 There was a view by those professionals that had contact with the family in this case that more needs to be done by agencies to instil confidence in Polish women to come forward and talk about their experiences and to improve their knowledge of the support services that are available to them. Such intervention would increase confidence in the community and improve intervention opportunities. It was felt that this could be achieved through targeted intervention at the main places of employment i.e. a meeting once a month within one of the two main workplaces in the County where all welfare and support issues could be addressed. Professionals felt that the approach to introducing domestic abuse awareness should be carefully considered so as not to deter people from attending (**Recommendation 9**).

7.5 <u>Operational Practice, Policy and Procedure</u>

7.5.1 The details provided by RCHT have identified that when Adult A was admitted to hospital in 2019 in relation to chest pain and diagnosed high blood pressure it was identified that there was a MARAC flag added to her records in 2017. These alerts apply to both adults and children within a household and ensure that staff are prompted to provide additional support and signposting. Where such a flag exists then the hospital IDVA is notified and this should be seen as good practice. The author of the RCHT chronology has however identified that as the flag had been added in 2017 it was outside the timeframe (one year) written in policy for contact (Safer Futures have confirmed that there was no contact with the hospital IDVA). The RCHT Panel representative has confirmed that the 'flagging' process is currently under review (**Recommendation 10**).

7.5.2 There was good evidence in records of IDVA contact in 2017 following a referral by the Police and that this individual initiated a face to face meeting at the earliest opportunity. Risk assessments, Severity of Abuse Grid (SOAG) and ISSP were completed in line with guidance and this should be seen as good practice. Contact was made with the support of an interpreter.

7.5.3 On the 09/11/17 a joint visit was made to see Adult A. On this occasion Adult A was provided with the details of a Polish Support Service by the IDVA. Research[23] has shown that many minority ethnic women experiencing domestic abuse/violence prefer to access support from a specialist BAME service and this was recognised by the IDVA and DAO. Safer Futures have however acknowledged that an area of learning for their organisation would be to initiate contact themselves for the client and arrange initial contact. This practice would assist in overcoming perceived barriers to help and support and engender confidence in using services **(Recommendation 11**).

7.5.4 At present it is recognised that more work needs to take place in terms of reaching out to all communities in Cornwall in respect of domestic abuse. It is therefore suggested that Safer Cornwall works with the Multi-Agency, Equality, Diversity and Hate Crime Group to identify opportunities to improve domestic abuse services , align strategies[24] and improve the training of frontline staff in the county to ensure that they are sensitive to cultural needs **(Recommendation 12).**

8.0 Conclusions

8.1 From the information that was made available to the Panel it would appear that Adult A found herself in a situation where she could see no alternative but to stay with her husband despite the abuse that she was suffering. Adult A felt financially and socially dependent upon him.

[23] In a survey of BAME women accessing domestic abuse/violence support services, found that 89% preferred a specialist BAME service. Thiara, R. & Roy, S. (2012) Vital Statistics 2: Key findings on black, minority ethnic and refugee women's and children's experiences of gender-based violence Imkaan. 8 Thiara, K. (2011) Refuge: Eastern European Community Outreach Project Thiara, K. (2011) Refuge: Eastern European Community Outreach Project Independent Evaluation Report Page 17 of 31 Copyright © 2015 Standing Together Against Domestic Violence.

[24] Safer Cornwall Domestic abuse and Sexual Violence Strategy (2019).

8.2 Adult A had suffered from domestic abuse over many years and the risks associated with that would appear to have been escalated through Adult B drinking alcohol.

8.3 Adult A's family have stated that they were unaware that she was in an abusive relationship with her husband and believed that she would have spoken out had she been a victim. The review has identified that it is likely that she remained 'silent' due to family loyalty, and the mistrust that some parts of the Polish community have in relation to dealing with agencies.

8.4 The cause and circumstances of Adult A's death remains 'unexplained'. There is no recorded evidence of an escalation to that risk in the days leading up to her death and no one could have foreseen the tragic events that occurred on the day of her death.

8.5 The review has identified a number of areas of learning in respect to agency response to the domestic abuse incidents reported by Adult A. When Adult A initially approached the police there was a lack of professional curiosity and a failure to follow established procedures and subsequent responses by all agencies were hampered by the inability to source interpreter services.

8.6 Those involved in the MARAC process failed to set appropriate actions and ensure that they were effectively followed up. Adult A's case would appear to have been finalised without a true appreciation of the complexities of her situation and an effective risk management plan being put into place. The MARAC process has since been strengthened by Safer Cornwall Partnership.

8.7 The review has identified that agencies could work harder to adapt current service provision to meet the needs of diverse groups living and working in the Cornish community.

8.8 Since the date of Adult A's death the MARAC process has continued to evolve in the County and is now robust in its approach to protecting victims. Agency policy and procedures in relation to domestic abuse would also appear to be comprehensive.

9.0 Learning

9.1 The learning opportunities identified in this case are listed by number and these correspond with the recommendations in section 10.0.

- Learning opportunity 1 (Recommendation 1)

  In March 2017 Adult A had an appointment with her doctor and during this consultation her family circumstances were not explored. There have been a number of DHR's that have been published in Cornwall which advocate that the use of routine enquiry by Health services should be promoted. In this case such an enquiry may have provided the opportunity to identify domestic abuse and signpost her to services.

- Learning opportunity 2 (Recommendation 2)

  Opportunities were identified by the review to improve the recording practices within Safer Futures in relation to the closure of cases and resulting actions from the MARAC.

- Learning opportunity 3 (Recommendation 3)

  Referral pathways and assertive outreach services are currently limited within the partnership for those engaging in abusive behaviours.

- Learning Opportunity 4 (Recommendation 4)

  Safer Futures identified that the true extent of abuse within the Polish community was difficult to determine due to current recording practices. Accurate recording of such information would enable agencies to track and forecast demographics and to implement appropriate changes to meet the needs of clients.

- Learning opportunity 5 (Recommendation 5)

  The Panel also acknowledged that there are issues with sourcing interpreters in a timely fashion in Cornwall.

- Learning Opportunity 6 (Recommendation 6)

  This case highlighted that operational police officers can, on occasions, have problems in appropriately sourcing interpreters.

- Learning opportunity 7 (Recommendation 7)

  The Panel members acknowledged that interpreters used in relation to domestic abuse cases would benefit from domestic abuse training.

- Learning opportunity 8 (Recommendation 8)

  The availability of multilingual literature across all agencies relating to domestic abuse services was found to be variable.

- Learning opportunity 9 (Recommendation 9)

  There was a view by those professionals that had contact with the family in this case that more needs to be done by agencies to instil confidence in Polish women to come forward and talk about their experiences and to improve their knowledge of the support services that are available to them.

- Learning opportunity 10 (Recommendation 10)

  The current MARAC flagging process in the hospital needs to be reviewed to ensure that all victims of domestic abuse are identified and provided with appropriate support.

- Learning opportunity 11 (Recommendation 11)

As part of the review Safer Futures acknowledged that practice should change to ensure that staff working on cases initiate contact on behalf of clients with other specialist support services. This practice would assist in overcoming perceived barriers to help and support and engender confidence in using services**.**

- Learning opportunity 12 (Recommendation 12)

The review identified that Safer Cornwall should work with the Multi-Agency, Equality, diversity and Hate Crime Group to identify opportunities to improve domestic abuse services , align strategies and improve the training of frontline staff in the County.

10.0 Recommendations

10.1 The learning opportunities identified in this case are listed below and have been translated into recommendations;

- Recommendation 1 – Safer Cornwall and Kernow Clinical Commissioning to work together to improve the responses of General Practices to domestic abuse through training, the establishment of care pathways, and an increase in GP referrals to specialist services and the MARAC.

- Recommendation 2 – Safer Futures to audit and review current recording practices to ensure that the decisions to close cases are defensible and that MARAC actions are finalised effectively and the rationale recorded.

- Recommendation 3 – Safer Futures and DASV commissioners to review current referral pathways and identify opportunities for improving services for individuals engaged in abusive behaviour.

- Recommendation 4 – Safer Futures to review and amend current recording practices to ensure that nationalities are accurately recorded for all cases.

- Recommendation 5 – Safer Cornwall Partnership to work with Health providers, Safer Futures, Housing and Adult Social Care to review and implement changes to improve local interpreter services in the County.

- Recommendation 6 – Devon and Cornwall Police to review current commissioning arrangements for interpreters and conduct an audit of domestic abuse cases that required an interpreter in terms of impact upon the outcomes for victims.

- Recommendation 7 – Safer Cornwall Partnership to work with Health providers, Safer Futures, Housing and Adult Social Care to review viability of training for local interpreters in domestic abuse.

- Recommendation 8 – Safer Cornwall Partnership to work with Health providers, Safer Futures, Housing and Adult Social Care to review and improve local domestic abuse literature for appropriate foreign national groups based on the demographics in the community.

- Recommendation 9 - Safer Cornwall Partnership, working with local specialist service providers who have experience of supporting Eastern European women experiencing

domestic violence/abuse, to identify the most effective way to increase awareness of domestic abuse, and support services, within that community and to develop an action plan to implement this.

- Recommendation 10 – RCHT to review the effectiveness of the MARAC flagging process and where appropriate implement identified changes.

- Recommendation 11 – Safer Futures to review current processes to ensure that staff make contact with specialist support services on behalf of clients.

- Recommendation 12 – Safer Cornwall should work with the Multi-Agency, Equality, diversity and Hate crime Group to identify and implement opportunities to improve domestic abuse services , align strategies and improve the training of frontline staff in the County.